Medicaid Program Highlights 2013

A Summary of Updates

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Agenda

- The Benefit Plan
- Rate Updates
- Care Management Organization
- New Regulations
- Grants
- Future Plans

The Benefit Plan

- Physician and Outpatient Services
- Behavioral Health Services
- Hospital Services
- Pharmacy Services
- Long Term Support Services
  - Nursing Facility
  - Community Based Services

Physician & Outpatient Services

- Added policy for telehealth services (more info in Medicaid Services Manual (MSM) Chapter 3400 and Web Announcements 521and 531)
- Added annual wellness visits for adults over age 21 (Web Announcement 580)
- Updated Bariatric Surgery policy by changing BMI criteria from 40 to 35
- Added a new EPSDT screen on the web portal (Web Announcement 579)
- Modified Therapy policy to require prior authorization

Behavioral Health Services

- Expanded telehealth services for licensed clinical psychologists, licensed clinical social workers and community mental health centers
- Updated day treatment policy to strengthen clinical milieu
- Removed post authorization requirements for crisis intervention

Hospital Services

- Added policy for State Licensed Free-standing Obstetric/Birthing centers
- Added policy for coverage of non-U.S. citizens who meet emergent coverage for dialysis services through the Federal Emergency Services program

Pharmacy Services

- Not necessarily new, but good to know:
  - Nevada Medicaid reimburses pharmacies for covered vaccines for adults and children administered in the pharmacy.
  - Nevada Medicaid offers a Lock-in program for recipients to be managed through a specific pharmacy for controlled substance prescriptions to deter fraud, waste and abuse. Currently, more than 500 recipients are in this program.

Nursing Facilities

- Developed an add on rate for the care of the behaviorally complex resident.
  - To provide specialized care for recipients who demonstrate medically-based behavior disorders resulting in a danger to self and/or others
  - Available for both in-state and out-of-state placement, though one goal is to provide for a recipient's care in-state.

  (For more information see MSM Chapter 500)

Community Based Services

- A five-year renewal of the WIN waiver was approved by the Centers for Medicare & Medicaid Services (CMS)
- A five-year renewal of the Waiver for Persons with Intellectual Disabilities is in process with CMS
- The Long Term Support Service quality assurance committee has been working with service providers and the Centers for Health Care Strategies to develop a combined home and community base service quality assurance system

Community Based Services

- The Personal Care Services (PCS) program updated service provision to allow recipients flexibility in how they utilize their PCS service hours.
- Personal Care Service staff, along with representation from PCS providers, physical and occupational therapists who complete program functional assessments, and HPES have been working on an updated, electronic functional assessment to improve consistency in service authorization.

Rate Restorations

- Ambulatory Surgical Centers (ASC) 15%
- Obstetrical/Gynecological 28%, and Pediatric Surgical providers 30%
- Ambulance service providers 15%
- Dental service providers .7% (seven-tenths of a percent)
- Anesthesia 6.86%

Primary Care Physician Rate Increase

- Rate increase (part of PPACA) for specific Primary Care Providers: Family Medicine, General/Internal Medicine, Pediatric Medicine or a subspecialty recognized by the American Board of Medical Specialties. Codes include Evaluation and Management (E&M) and vaccine administration codes. (Web Announcement 552)

End Stage Renal Dialysis (ESRD)

- A new rate methodology model for PT 45 and PT 12 ESRD providers to align with the new CMS methodology. CMS approved 8/15/13.
- High cost drugs and other services that used to be billed separately are now part of the bundled rate.

Care Management Organization

- Nevada received approval from CMS through a research and demonstration waiver (Section 1115 Waiver) to provide Care Management Services to high need/high cost recipients in our fee for service program who are not otherwise care managed.
- The goal is to improve quality of care, health outcomes and satisfaction while controlling costs (improved health, decreased re-hospitalization).
- This program will help recipients through transitions from inpatient to outpatient care and to follow through on health care needs.

Omnibus Rule HIPAA Changes

- Change to definition of "business associate" to include an entity that: creates, receives, maintains or transmits PHI
- Subjects business to the administrative, physical and technical safeguard requirements of the Security Rule
- Extends direct liability to disclosures of PHI by business associates
- Requires business associate to notify covered entities when it discovers a breach
- Extends HIPAA requirements applicable to business associates to subcontractors (subcontractors must enter into a business associate agreement with the primary business associate)
- Requires adherence to the minimum necessary requirement

ICD-10

- On **October 1, 2014,** the ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets.
- ***Everyone covered by HIPAA must be ICD-10 compliant starting on October 1, 2014.***
- State Medicaid programs must use ICD-10 for services provided on or after **October 1, 2014.**
- Stay up to date on ICD-10 at: **http://cms.gov/Medicare/Coding/ICD10/ProviderResources.html**

Grants

- Money Follows the Person – goal is to transition persons from institutional based care to community based, person centered, consumer directed care. ($9.9M, 2011 – 2016)
- Medicaid Incentives for the Prevention of Chronic Diseases – study of the use of incentives in the Medicaid population to encourage prevention and healthy behaviors to control disease and improve outcomes ($3.5M, 2011 – 2015)
- Medicaid partners with sister agencies on grant applications

Future Plans

- Expansion of Substance Abuse Policy to follow the American Society of Addictive Medicine program model (Policy and workshops ongoing with a January 1, 2014, implementation goal)
- Integration of Long Term Support Services resulting in two home and community base waivers (ICF/ID and NF). Goals are no wrong door, integrated suit of service, reduction of duplication. (Full implementation July 2016)
- Application for the CMS Balancing Incentive Payment Program to provide higher federal match to improve and increase community based long-term support services

Questions?

Thank you for your attention